University of Connecticut
Health Center
John Dempsey Hospital

Name
MR#: [redacted]

CLINICAL RECORD - INPATIENT

11/26/2012	ICU APRN Admission Note	ICU day #1; HD #1

CC/HPI

Mr [redacted] is a 76 yr old Caucasian male with a PMH of DM, HTN, and CAD who underwent a cardiac workup prior to carpal tunnel surgery, ultimately resulting in a cardiac catheterization revealing severe three-vessel coronary artery disease with a normal left ventricular function. He reported symptoms of dyspnea on exertion, but no CP otherwise. Today he underwent a CABG x4(Circ --> diag LIMA-->LAD). Postoperatively he was transferred to the ICU intubated and sedated, and epinephrine and neosynephrine infusions running. He received in total of 2L NS boluses throughout the afternoon, and neosynephrine was quickly weaned to off. Epinephrine has been transiently on and off at low doses to maintain a MAP >65, and the patient was weaned and extubated early this evening. He was oxygenating well on 4L NC O2. After falling asleep, he was placed on his home Bipap settings of 12/5 with RA. He currently remains on low dose epinephrine, and he is resting comfortably in bed with the Bipap mask in place.

Intra-Op Course

Difficult intubation, no problems placing on and off CPB, total CPB time: 151, xclamp time: 121, normal LV function post CPB, defib x2, cell saver 950mL, 2200mL crystalloid no blood products. 500mL UO, off CPB on epinephrine and neosynephrine infusions post-op, initially AV paced rate of 80.

PMH:

C. Dif colitis
DM
HTN
BPH
Hyperlipidemia
GERD
Renal Insufficiency
Sleep apnea (on home Bipap 12/5 with RA)
Basal cell carcinoma s/p resection

PSH:

Gallbladder removal
Basal cell carcinoma resection

[redacted]

11/26/2012 20:58

Patient: [redacted] MRN: [redacted] Encounter: [redacted] [redacted]

Soc Hx:

Pt was born in Scotland. He is married with 3 children, one of whom had CABG at age 42. He is independent in his ADLs. He is not employed and reports a 10yr history of smoking 10 cigarettes/day but quit >35 yrs ago. He does not report current ETOH, tobacco, or illicit drug usage.

FH:

Per documents in chart, pt's mother and father died of cancer. His brother also had cancer from occupational hazards/asbestos exposure.

ROS:

Deffered secondary to intubation and sedation

Home Meds:

(per documentation in chart)

Amlodipine 5mg PO qAM
Aspirin 325mg PO daily
Finasterice 5mg PO daily
Glyburide 1 tab PRN glucose >140
Lisinopril 20mg PO daily
Nebivolol 10mg PO qAM
Pantoprazole 40mg PO daily
Simvastatin 20mg PO qHS
Tamsulosin 0.4mg PO qAM

Allergies:

NKDA

Diagnostics:

11/5/12 Carotid Doppler: 1. The bilateral internal carotid arteries reveal no evidence of significant stenosis.
2. The external carotid arteries reveal no significant stenosis. There is mild degree of stenosis involving both carotid bifurcations.This is due to mild to moderate heterogeneous plaque in the right carotid bulb and distal right common carotid artery as well as moderate heterogeneous plaque in the left carotid bulb. There is

also mild non-calcified plaque in the distal left common carotid artery. These areNOT hemodynamically significant. 3. The bilateral vertebral arteries are patent with normal antegrade flow. 4. The bilateral subclavian arteries reveal no evidence of significant stenosis.

Cardiac Cath:

(per outpatient notes from Waterbury Hospital)

Date of study: 10/23/12 Impressions: 1. Left main artery large in size with mild disease. 2. Left anterior descending artery with 90% proximal stenosis, mid segment with 90-95% stenosis. The distal vessel is large with moderate disease. D1 & D2 are at the proximal and mid segments right at the previously noted stenosis. They are both calcified with 80 to 90% ostial stenoses. 3. Left circumflex artery is a large dominant system. OM1 is small, OM2 branching large vessel. Lower branch of this vessel with 80 to 90% stenosis, distal to this a 70 to 80% stenosis in the left circumflex artery prior to the take off of large left posterolateral branch, which has mild disease and LPDA is also moderate to large in size with 80 to 90% proximal stenosis. 4. RCA is small nondominant vessel with 95% proximal stenosis. 5. LVEF of 60%.

T°	P	RR	BP	SaO2	CVP
97.4	92 SR	14	111/52 (70)	96% on 40% FIO2	16

MODE	Rate	TV	FIO2	PEEP	SA02
AC	14	600	40%	5	96%

Exam

General: Intubated, sedated pale Caucasian male lying in bed in no acute distress

HEENT: Normocephalic, atraumatic; pupils equel and sluggishly reactive, 3 mm constricting to 2mm, sclera injected, + chemosis, oral mucosa pink and moist, no leukoplakia but small purple area on L tip of tongue, OGT in place to LCWS, #8 ETT at 24cm at the lip

Chest: Midline sternal incision, edges intact and approximated open to air, no drainage noted, 2 mediastinal and 1 pleural CT to 20cmH2O wall suction, no air leak noted, all draining very small amount thin sanguinous drainage to chamber

Neck: Supple, trachea midline, 2+ carotids, no bruit auscultated, no JVD appreciated, R IJ cordis with slic in place, site benin, dressing CDI

Heart: RRR, S1 soft, S2 soft with + pericardial rub auscultated loudest at 5th ICS, L sternal border, no murmur or gallop appreciated, PMI 5th ICS, MCL, no lifts or heaves

[redacted]

Lungs: Clear throughout with decreased breath sounds in bilateral bases, no wheezes or ronchi noted
Abd: Soft, no grimace to palpation, + but hypoactive BSs throughout, no organomegaly appreciated, tympanic to percussion.
GU: Foley to gravity with clear yellow urine, external anatomy normal in appearance.
Extremities: Warm upper extremities with 2+pulses in radials, Doppler pulses bilateral pedal pulses with LEs slightly cool and pale, nail beds pale with 3 second capillary refill, no clubbing, multiple small bruises on fingertips, trace to 1+ UE edema and +3 pitting LE edema, R radial aline site benign, dressing CDI, R leg with ace wrap and hemovac extending from beneath, hemovac to self suction with trace serosanguinous drainage in tubing
Neuro: Assessment limited secondary to sedation, but pt will nod and follow simple commands, and moves all extremities to touch. No facial droop or ptosis appreciated.

Labs

Pre-Op CABG

11/20/12 1156

141	107	25	Gluc	iCa	1.25	WBC	H/H	Plt	Bands
4.6	27	1.6	181	PO4	3.9	12.1	14.3	214	
				Mag	1.5		41.6		

PT	12.0
PTT	25.8
INR	1.1

Fibrinogen: 409 Albumin: 3.0 Bili T/D: 0.6/0.1

Thrombin Time: 16.2 AST: 31

TSH: 1.42 ALT: 32

HgA1c: 6.4 Alk Phos: 91

Post op CABG

11/26/12 1515

141	111	21	Gluc	iCa	1.19	WBC	H/H	Plt	Bands
4.4	22	1.4	138	PO4	3.2			126	
				Mag	1.9		31.6		

PT	15.5
PTT	28.8
INR	1.7

Fibrinogen: 214

Thrombin time: 20.3

VENT:	PH	CO2	PO2	HCO3	O2 sat
ABG: AC 14-600-40% - 5 peep	7.32	41	76.1	21.4	94.3%

[redacted]

Patient: [redacted] MRN: [redacted] Encounter [redacted]

Cultures:

none

Diagnostic Tests:

11/26/12 EKG: SR rate 92, PR: 0.16, QRS: 0.12, QT: 0.38; T wave inversion III, AVF, & V1 with ?in II as well, similar to pt's baseline EKG; new incomplete R BBB

11/26/12 CXR: Fair inspiratory effort, overpenetrated, BL effusions v. atelectasis, R IJ coreis --> SVC, ETT 5cm above carina, OTs x3, OGT --> below diaphragm (pt extubated shortly thereafter)

ICU Meds

Sucralfate 1 gr OGT Q6hr while intubated
Pantoprazole 40 mg PO daily when intubated
Cefuroxime 1.5 gr IV Q 8 hr X3
Pneumococcal vaccine
Influenza vaccine
Heparin 5000 units SC to start in the am
NS at 50 ml/hr total all drips
RISS
Folic acid 1 mg PO daily
Thiamine 100 mg PO daily
Cyanocobalamin 250mcg PO daily
Ascorbic acid 500 mg PO daily
Ferrous sulfate 324 mg PO TID
Docusate 100 mg PO BID
Epinephrine infusion
Tamulosin 0.4mg PO qAM
Finasteride 5mg PO daily
Atorvastatin 20mg PO qPM
PRN: hydromorphone, midazolam, ondansetron

Lines:

R IJ Cordis with slic (inserted 11/26/12) : Dressing CDI, site benign
R radial a-line (inserted 11/26/12) : Dressing CDI, site benign

[redacted]

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Assessment & Plan
Mr. [redacted] is a76 yr old male s/p CABG x4, admitted to the ICU for continued hemodynamic and respiratory management.
Neurological: No focal deficits. Pain control→ hydromorphone PRN with good effect. Activity--> OOB to chair on POD #1.
Cardiovascular: CAD s/p CABG x3 → pt currently requiring epinephrine infusion to maintain MAP >65. Utilize gentle volume resuscitation with small NS boluses to attempt to reduce epinephrine requirements. If needed for further pressor support, may consider restarting neosynephrine infusion. A & V pacer wires attached to pacemaker with backup rate of 60. CT output minimal; continue to monitor closely. Hx of HTN, however not a current issue--> home antihypertensives on hold. If SBP increases >140 off of pressors, restart home antihypertensives and consider initiating nitroprusside if necessary to keep SBP <140 to protect grafts. On aspirin 324mg PO daily for graft patency. Restart beta blocker tomorrow for arrhythmia prophylaxis once off pressors and hemodynamically stable. Hx hyperlipidemia--> home atorvastatin restarted.
Pulmonary: Pt extubated to 4L NC O2 this evening and continues to oxygenate well, maintaining O2 sats >94%. Wean oxygen as tolerated to RA to maintain O2 sats >94%. IS q 1 hr and good pulmonary toileting. Hx OSA--> on home Bipap qHS and while napping
FEN: Hx of renal insufficiency, creatinine post-op 1.4. Monitor daily, avoid nephrotoxins, and maintain MAP >65 for adequate renal perfusion. IVF with NS for total all gts of 50mL/hr. Calcium & magnesium repleted. Repeat lytes at 9pm and again in AM; replace to maintain K+ >4.0, Mg+ > 2.0, and iCa+ >1.2 for arrhythmia prophylaxis.
GI: Advancing diet as tolerated to cardiac 2gm Na+, 60gm fat, no concentrated sweets. Hx of GERD--> on pantoprazole. Ondansetron PRN nausea. Hx of c. Diff colitis--> no diarrhea at this time; continue to monitor.
GU: Hx of BPH--> restarted on home tamsulosin and finasteride.
Endocrine: Hx of DM-->Fingersticks q4hrs with RISS coverage. For two consecutive FSs >180, initiate insulin infusion for improved glycemic control. TSH WNLs in pre-op bloodwork.
ID: Periop prophylaxis with cefuroxime x3 doses.
Hematology/Oncology: Acute blood loss anemia secondary to surgical procedure→ will continue to monitor Hct at 9pm and again in AM. If Hct <24, notify surgeon prior to transfusing. Coagulopathy→ coags mildly elevated postoperatively but CT drainage minimal and no s/s appreciable bleeding noted. Continue to monitor.

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Prophylaxis: DVT prophylaxis→PAS, heparin SC to start POD #1 GI prophylaxis→ sucralfate while intubated, then pantoprazole in the AM VAP prophylaxis→ HOB >30 degrees, frequent oral care

Disposition [redacted] continues to require hemodynamic and respiratory monitoring and ICU level care s/p CABG. He was seen and discussed with [redacted] He is a full code. His family was updated at the bedside.

[redacted]

[redacted]